

DATE OF RIDE-ALONG: _____
(To be completed by Nightingale)

**NIGHTINGALE REGIONAL AIR AMBULANCE
RIDE-ALONG PROGRAM APPLICATION**

Please print all information:

NAME: (last) (first) (middle initial)		
ADDRESS: (street) (city) (state) (zip code)		
PHONE: () _____ - _____ () _____ - _____ (home) (work)		
CURRENT EMS/HOSPITAL EXPERIENCE	DATES	RESPONSIBILITIES
affiliation address	from to	
affiliation address	from to	
CURRENT SUPERVISOR _____ PHONE () _____ - _____ (print name)		

Do you have any physical limitations we should know about? If so, please list:

Present weight fully clothed: _____ **Height:** _____
(weight will be verified on date of ride along because of program restrictions-190 lb limit fully dressed)

Briefly explain on the back of this application your interest in our Ride-Along Program and what you expect to gain from your experience.

Applicant's signature: _____ **Application date** ____/____/____

Training officer's/Nurse Manager's name: _____
Training officer's/Nurse Manager's signature: _____

revised 4/03:rialappl

Ridealongapp